

To the Honorable Members of the Appropriations Committee:

I would like to express my opposition as a pediatrician and Co-chairperson of the State's Child Fatality Review Panel regarding the Governor's budget reform proposal in HB 6353. It is my understanding that this proposal would **essentially eliminate any separate appropriation for the Child Advocate's office, and gives all appropriations authority to the Executive Administrator, who reports to the Governor. This would decimate the Office of the Child Advocate's independence and functioning.**

The independent functioning of the Child Advocate's Office supports the work of the state's Child Fatality Review Panel (CFRP), which is seen as a national model for the review of childhood deaths so as to determine ways of preventing untimely childhood deaths in the future. Connecticut General Statutes §46-13k established the state's CFRP to review the circumstances surrounding all unexplained or unexpected child deaths. The statutory authority for the CFRP is embedded in the Office of the Child Advocate (OCA) statute.

The CFRP reviews a child's death to determine whether there were contributing risk factors that could be impacted by systemic interventions. Identified risk factors are then incorporated into proposed prevention initiatives designed to decrease the incidence of such deaths. The CFRP conducts a full fatality investigation of deaths where state agencies or state-supported services either were or should have been involved in the child's life prior to death. The goal of these investigations is to determine the effectiveness of state programs, and to identify what actions or changes can be made to improve the policies, practices, procedures, or the structure of the programs themselves.

For example, the CFRP's review of the death of 7 month old under protective supervision by DCF is an example of the importance of a timely and comprehensive fatality investigation. In May 2010 the OCA released a public report on the homicide of this infant. The report outlined 15 comprehensive recommendations for systemic reform. Throughout the course of the investigation, critical findings were provided to the DCF. One of the major findings was related to the long-standing practice of recording reports and investigations of DCF employees in a paper record only, rather than in the Department's electronic database. This practice was halted and a several month process ensued to enter all of those paper records into the database. Other recommendations included improving the recruitment, training, support, and assessment of foster parents, as well as enhancing and expanding family-centered practice to focus on families needing substance abuse and mental health treatment.

The OCA's budget proposal to the Office of Policy and Management for the 2015 biennium is \$556,531/\$598,531 for FY 14/15; the budget proposal for the Child

Fatality Review Panel is \$95,884/\$101,471 for FY 14/15. The OCA totals therefore are \$652,237 for FY 2014 and \$700,002 for FY 2015.

**The CFRP reviews approximately 250 deaths per year; the cost of such review is \$397 for each unforeseen childhood death. Is it not worth the cost to investigate the untimely death of each child in Connecticut so as to prevent future, unnecessary and untimely childhood deaths?**

Thank you for your consideration of my testimony.

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